

# **EXHIBIT A**

V54 - ISS REV. 1/20 DEPARTMENT OF PUBLIC HEALTH		STATE OF CONNECTICUT CERTIFICATE OF DEATH		STATE FILE NUMBER (For State Use only. Do not write in this box.) 2022-07-033165	
DECEDENT	1. LEGAL NAME First <b>Sharon</b>	Middle -----	Last <b>Masotta</b>	Suffix -----	2. SEX <b>Female</b>
	3. DATE OF DEATH (Month/DD/YYYY - Spell Month) <b>December 23, 2022</b>		4. TIME OF DEATH <b>02:24 AM</b>		
	5. AGE LAST BIRTHDAY <b>66</b>		6. Under 1 Year Mo. Days Hours Min.		
PARENTS	7. DATE OF BIRTH (MM/DD/YYYY) [REDACTED]		8. BIRTHPLACE (City, State or Foreign Country) <b>New Haven, Connecticut</b>		
	9. RESIDENCE (State) <b>Connecticut</b>	10. RESIDENCE (County) <b>New Haven</b>	11. RESIDENCE (City or Town) <b>Northford</b>	12. RESIDENCE (Street and No.) <b>473 Village Street</b>	13. APT. NO. -----
	14. ZIP CODE <b>06472</b>		15. EVER IN US ARMED FORCES? <b>No</b>		
P.O.D.	16. MARITAL STATUS AT TIME OF DEATH <b>Married</b>		17. SURVIVING SPOUSE NAME (Full name prior to first marriage) <b>James P. Masotta</b>		
	18. FATHER/PARENT NAME (Full name prior to first marriage) <b>Vincent D. Baldino</b>		19. MOTHER/PARENT NAME (Full name prior to first marriage) <b>Janice Walker</b>		
	20. INFORMANT NAME <b>James P. Masotta</b>		21. RELATIONSHIP TO DECEDENT <b>Spouse</b>		
DISPOSITION	22. MAILING ADDRESS (Street and Number, City, State, Zip Code) <b>473 Village Street Northford, Connecticut 06472</b>		23. IF DEATH OCCURRED IN A HOSPITAL: <b>Hospital - Inpatient</b>		
	24. IF DEATH OCCURRED SOMEWHERE OTHER THAN HOSPITAL		25. FACILITY NAME (If not institution, give street & number) <b>Yale New Haven Health - York St. Campus</b>		
	26. CITY OR TOWN OF DEATH <b>New Haven</b>	27. COUNTY OF DEATH <b>New Haven</b>	28. METHOD OF DISPOSITION <b>Burial</b>		
MEDICAL CERTIFICATION	29. DISPOSITION (Name of cemetery, crematory, other) <b>All Saints Cemetery</b>		30. LOCATION (City/Town) (State) <b>North Haven, CT</b>	31. DATE (MM/DD/YYYY) <b>12/27/2022</b>	32. WAS BODY EMBALMED? If yes, Name of Embalmer <b>Robert Patton</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
	33. FUNERAL FACILITY-Name and Address (Street, Town, State, Zip) <b>Porto Funeral Home (West Haven) - 830 Jones Hill Rd, West Haven, CT 06516</b>		34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER <i>Albert M. Delucia</i> Signature Electronically Authenticated		35. LICENSE NUMBER <b>2220</b>
	36. DATE PRONOUNCED DEAD (MM/DD/YYYY) <b>12/23/2022</b>	37. TIME PRONOUNCED <b>02:40 AM</b>	38. PRONOUNCER'S NAME AND DEGREE OR TITLE <b>Ayomipo Madein, Doctor of Medicine</b>		Pronouncer License # <b>66009</b>
MEDICAL EXAMINER ONLY	39. WAS MEDICAL EXAMINER CONTACTED? <b>No</b>		40. WAS AN AUTOPSY PERFORMED? <b>Unk</b>		41. WERE THE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? -----
	42. PART I. Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.				APPROXIMATE INTERVAL ONSET TO DEATH
	IMMEDIATE CAUSE (Final disease or condition resulting in death) -----> (a) <b>Large bowel obstruction</b>				<b>12/8/2022</b>
	Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to the cause listed on line (a). Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST (d) -----				<b>5/1/2020</b>
	Due to (or as a consequence of):				
43. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. <b>hypoxic respiratory failure</b>				44. PREGNANCY STATUS: <b>Not Applicable</b>	
45. DID TOBACCO USE CONTRIBUTE TO DEATH? <b>No</b>					
46. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined					
MEDICAL EXAMINER ONLY	47. DATE OF INJURY (MM/DD/YYYY) -----	48. TIME OF INJURY -----	49. PLACE OF INJURY (Home, construction site, wooded area, etc.) -----		50. INJURY AT WORK? -----
	51. LOCATION OF INJURY (Street, Apt. #, City/Town, State, Zip Code) -----		52. DESCRIBE HOW INJURY OCCURRED -----		53. IF TRANSPORTATION INJURY, SPECIFY -----
	54. M.E. CASE NUMBER -----				
CERTIFIER STATEMENT: To the best of my knowledge, death occurred due to the cause(s) and manner stated.					
CERTIFIER	55. CERTIFIER NAME (type or print) <b>Ayomipo Madein</b>		Certifier Signature <i>Ayomipo Madein</i> Signature Electronically Authenticated	Title of Certifier <b>Doctor of Medicine</b>	Certifier License # <b>66009</b>
	56. MAILING - CERTIFIER (Street) <b>20 York St, New Haven CT 06510</b>		(City or Town) -----	(State) -----	(Zip) -----
REGISTRAR	THIS CERTIFICATE WAS RECEIVED FOR RECORD ON: <b>12/27/2022</b>		BY <i>Patricia Clark</i> REGISTRAR		
	57. DECEDENT EDUCATION <b>High School Graduate/GED</b>		58. DECEDENT OF HISPANIC ORIGIN? <b>No, not Spanish/Hispanic/Latino</b>	59. DECEDENT RACE <b>White</b>	
	60. DECEDENT USUAL OCCUPATION <b>Data Entry</b>		61. KIND OF BUSINESS/INDUSTRY <b>Sargent Co. &amp; Ulbrich Steel</b>	62. SOCIAL SECURITY NUMBER [REDACTED]	
MARGINAL NOTES					
THE SEAL OF THE ISSUING OFFICE IS AFFIXED TO CERTIFY THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE IN THE STATE OF CONNECTICUT					
DATE ISSUED: <b>December 27/2022</b>					
PLACE OF ISSUANCE: <b>New Haven City Hall</b>					
ISSUING REGISTRAR SIGNATURE: <i>Patricia E. Clark</i>					